Adult Outpatient Behavioral Health (OY0101)

NIH National Institutes of Health
Clinical Center

Dear {FIRST_NAME} {LAST_NAME}, or parent or guardian of:

Our mission at the NIH Clinical Center is to provide our patients with the highest quality health care that we can. To accomplish this, we need to know what we are doing right and what needs improvement. We depend on our patients and their families to keep us informed.

By sharing your thoughts and feelings about your health care experience on {DISDATE}, you can help make our care better for future patients and their families. Please take a few minutes to complete the following patient experience survey. If you choose not to participate, this will not affect your care.

Thank you for your participation.

Sincerely,

James K. Gilman, M.D.
Chief Executive Officer
NIH Clinical Center

Start Survey

NIH National Institutes of Health
Clinical Center

INSTRUCTIONS: Please rate the ***services*** you received ***from our facility***. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

If you can't complete the entire survey at once, you may come back to it later. Your previous responses will be saved automatically and you will be able to continue where you left off. At any point during the survey, you can clear the entire survey and start over by clicking the "Clear Survey" button.

When you have finished, please click the "Submit" button.

OMB No. 0925-0648 Expiration Date: 06/2024

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0648).

Continue

ADULT OUTPATIENT SURVEY

0%

ACCESS

Ease of getting an appointment

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Convenience of available appointment times

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Comments (describe good or bad experience):

ADULT OUTPATIENT SURVEY

15%

CLINICAL AREA

Cleanliness of the clinical area

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Privacy of the clinical area

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Comfort level in and around the clinical area

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Comments (describe good or bad experience):

ADULT OUTPATIENT SURVEY

29%

CARE PROVIDERS

YOUR CARE PROVIDER IS THE PERSON WHO ADDRESSES YOUR MEDICAL NEEDS INCLUDING ANY PRESCRIPTIONS FOR MEDICATIONS. YOUR CARE PROVIDER MAY BE A PSYCHIATRIST, MEDICAL DOCTOR, PHYSICIAN ASSISTANT (PA), OR NURSE PRACTITIONER (NP). PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

Courtesy and respect of the care provider

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Helpfulness of time spent with the care provider

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

How well the care provider informed you about your medication (if you were prescribed medication)

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Comments (describe good or bad experience):

ADULT OUTPATIENT SURVEY

43%

THERAPIST(S)

If you did not see a Therapist during this visit, please skip this section. Thank you.

Your trust in the skill of the therapist(s)

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Therapist's concern for your questions and worries

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

How well the therapist(s) understood you and your needs

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

How well the therapist(s) kept you informed about your treatment

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Therapist(s) Section Comments

ADULT OUTPATIENT SURVEY

58%

YOUR CARE

Staff's concern for your privacy

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

How well the staff addressed your emotional needs

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Staff's response to concerns/complaints made during your care

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Staff's efforts to include you in decisions about your care

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Instructions on what to do if experiencing problems related to your condition (when to seek help, who to call, etc.)

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Degree of safety and security you felt in our facility

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Comments (describe good or bad experience):

ADULT OUTPATIENT SURVEY

72%

OVERALL ASSESSMENT

How well the staff worked together to care for you

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Overall rating of care given at this facility

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Likelihood of your recommending this facility to others

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

Comments (describe good or bad experience):

ADULT OUTPATIENT SURVEY

86%

Patient's Name: (optional)

Telephone Number: (optional)